Pharmacy

Drug Utilization Review and Pharmaceutical Care

wisconsin Medicaid and BadgerCare

Wisconsin Medicaid and BadgerCare Information for Providers

Department of Health and Family Services

Pharmacy Quick-Reference Page

Pharmacy Point-of-Sale (POS) Correspondents

For questions regarding Medicaid policies and billing, please call:
(800) 947-9627 or (608) 221-9883; select "2" when prompted.

Hours available: 8:30 a.m. to 6:00 p.m. Monday, Wednesday, Thursday, and Friday.
9:30 a.m. to 6:00 p.m. Tuesday.
Not available on weekends or holidays.

Clearinghouse, Switch, or Value-Added Network (VAN) Vendors

For transmission problems, call your switch, VAN, or clearinghouse vendor:

- Healtheon/WebMD switching services: (800) 433-4893.
- Envoy switching services: (800) 333-6869.
- National Data Corporation switching services: (800) 388-2316.
- QS1 Data Systems switching services: (864) 503-9455 ext. 7837.

Electronic Media Claims (EMC) Help Desk

For any questions regarding EMC (tape, modem, and interactive software), please call:
(608) 221-4746 Ext. 3037 or 3041.

Hours available: 8:30 a.m. to 4:30 p.m. Monday through Friday.
Not available on weekends or holidays.

Wisconsin Medicaid Web Site

www.dhfs.state.wi.us/medicaid/

- Pharmacy handbook, replacement pages, and *Wisconsin Medicaid and BadgerCare Updates* on-line and available for viewing and downloading.
- Pharmacy POS information.

Fax Number for Prior Authorization (PA)

(608) 221-8616

Paper PA requests may be submitted by fax.

Specialized Transmission Approval Technology — PA (STAT-PA) System Numbers

For PCs:
(800) 947-4947
(608) 221-1233
Available from 8:00 a.m. to 11:45 p.m., seven days a week.

For touch-tone telephones:
(800) 947-1197
(608) 221-2096
Available from 8:00 a.m. to 11:45 p.m., seven days a week.

For the Help Desk:
(800) 947-1197
(608) 221-2096
Available from 8:00 a.m. to 6:00 p.m., Monday through Friday, excluding holidays.

Important Telephone Numbers

Wisconsin Medicaid's Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility.

Service	Information available	Telephone number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Info. Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Info. Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/Billing and Eligibility: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Pharmacy/DUR: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Info. Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)
Recipient Services (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720	7:30 a.m. - 5:00 p.m. (M-F)

*Please use the information exactly as it appears on the recipient's identification card or EVS to complete the patient information section on claims and other documentation. Recipient eligibility information available through EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

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Preface

The Wisconsin Medicaid and BadgerCare Pharmacy Handbook is issued to pharmacy providers who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% (as of January 2001) of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

Verifying Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this section for detailed information on the methods of verifying eligibility. If you are billing a pharmacy claim through real-time Point-of-Sale (POS), eligibility verification is part of the claims submission process.

Handbook Organization

The Pharmacy Handbook consists of the following sections:

- Claims Submission.
- Covered Services and Reimbursement.
- Drug Utilization Review and Pharmaceutical Care.
- Pharmacy Data Tables.
- Prior Authorization.

In addition to the Pharmacy Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following subjects:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

Legal Framework of Wisconsin Medicaid and BadgerCare

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430-456 — Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.497 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101-108.

Handbooks and *Wisconsin Medicaid and BadgerCare Updates* further interpret and implement these laws and regulations.

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information about Wisconsin Medicaid and BadgerCare are available at the following Web sites:

www.dhfs.state.wi.us/medicaid
www.dhfs.state.wi.us/badgercare

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS, to provide health claims processing, communications, and other related services.

Drug Utilization Review

Omnibus Budget Reconciliation Act of 1990 Requirements

Although Medicaid's prospective DUR system alerts pharmacy providers to a variety of potential problems, it is not intended to replace pharmacists' professional judgement.

The federal Omnibus Budget Reconciliation Act of 1990 (OBRA `90) established Medicaid program requirements regarding several aspects of pharmacy practice. One of the requirements of OBRA `90 was a Drug Utilization Review (DUR) program for Medicaid outpatients to improve the quality and cost-effectiveness of recipient care.

Providers should refer to Phar. 7.01(1)(e) and 7.08, Wis. Admin. Code, and 450.01(16)(i), Wis. Stats., for detailed information about Wisconsin's DUR requirements.

The OBRA `90 requires that Medicaid DUR programs should have all the following:

- Prospective DUR.
- Retrospective DUR.
- An educational program using DUR program data on common drug therapy.

Individual pharmacies are responsible for prospective DUR, while Wisconsin Medicaid is responsible for the retrospective DUR and the educational program. Further differences can be found in the table at right.

Prospective vs. Retrospective Drug Utilization Review

Prospective Drug Utilization Review

- Performed before a drug is dispensed.
- Identifies a potential problem before it occurs.
- Provides real-time response to a potential problem.
- Has preventive/corrective action.

Retrospective Drug Utilization Review

- Performed after a drug is dispensed.
- Warns when a potential problem has occurred.
- Useful for detecting patterns.
- Useful for designing targets for intervention.
- Has corrective action.

Prospective Drug Utilization Review

To help individual pharmacies comply with their prospective DUR responsibility, Wisconsin Medicaid developed a prospective DUR system. The system screens certain drug categories for clinically significant potential drug therapy problems before the prescription is dispensed to the recipient. Prospective DUR enhances clinical quality and cost-effective drug use.

When a claim is processed for a drug that has the potential to cause problems for the recipient, Wisconsin Medicaid returns an alert to inform the pharmacy provider of the potential problem. The provider is then required to respond to the alert to obtain reimbursement from Wisconsin Medicaid. The provider is required to resubmit the claim and include information about action taken and the resulting outcome.

Please note: although Medicaid's prospective DUR system alerts pharmacy providers to a variety of potential problems, it is not intended to replace pharmacists' professional judgement. Potential drug therapy problems may exist which do not trigger the Prospective DUR system. Prospective DUR remains the responsibility of the pharmacy, as required by federal and state law. Medicaid's system is an additional tool to assist pharmacists in meeting this requirement.

The Wisconsin Medicaid DUR Board, required by federal law, consists of three physicians, five pharmacists, and one nurse practitioner. The board and the Department of Health and Family Services (DHFS) reviews and approves all DUR criteria and establishes the hierarchy of alerts.

Claims to Be Reviewed by the Prospective Drug Utilization Review System

Under the prospective DUR system, only reimbursable claims for Medicaid fee-for-service recipients submitted through real-time Point-of-Sale (POS) are reviewed. Although paper claims, compound drug claims, and electronic media claims are *not* reviewed by the Medicaid prospective DUR system, pharmacy providers are still required under provisions of OBRA `90 to perform prospective DUR independently.

Real-time claims for nursing home recipients are reviewed through the prospective DUR system; however, they do not require a response to obtain reimbursement since billing for these recipients does not always occur at the same time the drug is dispensed. The nursing home pharmacist consultant continues to be responsible for prospective DUR.

Prospective Drug Utilization Review Alerts and Alert Hierarchy

For each recipient, Wisconsin Medicaid activates alerts that identify many potential problems. The Wisconsin Medicaid DUR Board established a hierarchy for the order in which multiple alerts appear if more than one alert is activated for a drug claim. Factors taken into account in determining the hierarchy include the potential for avoidance of adverse consequences, improvement of the quality of care, cost savings, likelihood of a false positive, retrospective DUR experience, and a review of alerts used by other state Medicaid programs for prospective DUR. The clinical drug tables used to establish the alerts are provided to Wisconsin Medicaid by First DataBank, Inc.

Wisconsin Medicaid activates alerts that identify the following problems, which are presented in hierarchical order:

1. Drug-drug interaction (DUR conflict code DD).
2. Drug-disease contraindication (reported [MC] and inferred [DC]).
3. Therapeutic duplication (TD).
4. Pregnancy alert (PG).
5. Early refill (ER).
6. Additive toxicity (AT).
7. Drug-age precaution (pediatric [PA]).
8. Late refill (LR).

Drug-Drug Interaction

Wisconsin Medicaid activates this alert when another drug in claims history may interact with the drug being filled. The system reviews not only the prescriptions at the provider's pharmacy, but all of the prescriptions reimbursed by Medicaid fee-for-service.

Drug-Disease Contraindication (Reported and Inferred)

Wisconsin Medicaid activates this alert when a drug is being prescribed for a recipient with a disease for which the drug is contraindicated. Acute diseases remain in the recipient's medical profile for a limited period of time, while chronic diseases remain permanently. The disease may have been reported on a medical claim, or inferred from a drug in claims history:

1. *Reported.* The diagnosis is extracted from the recipient's medical profile, which includes previously reimbursed claims, including pharmacy claims where a diagnosis is submitted.
2. *Inferred.* Wisconsin Medicaid infers that the recipient has a disease based on a drug present in claims history. This inference is made if there is one and only one disease indicated for the drug.

Although paper claims, compound drug claims, and electronic media claims are *not* reviewed by the Medicaid prospective DUR system, pharmacy providers are still required under provisions of OBRA `90 to perform prospective DUR independently.

Therapeutic Duplication

Wisconsin Medicaid activates this alert when another drug is present in claims history that has the same therapeutic effect as the drug being dispensed. The message sent to the provider includes the drug name in claims history that is causing the alert. The therapeutic areas for the duplication alert may include but are not limited to:

- Angiotensin converting enzyme (ACE) inhibitors.
- Oral antifungals.
- Antilipidemics.
- Oral contraceptives.
- Anxiolytics.
- Oral glucocorticoids.
- Benzodiazepines.
- Phenothiazine antipsychotics.
- Diuretics.
- Proton pump inhibitors.
- H-2 antagonists.
- Sedative/hypnotics.
- Narcotic analgesics.
- SSRIs/other new antidepressants.
- Non-sedating antihistamines.
- Sulfonylureas.
- Non-steroidal anti-inflammatory drugs (NSAIDs).

Pregnancy Alert

Wisconsin Medicaid activates this alert when the prescribed drug is contraindicated in pregnancy. This alert is activated when all of the following conditions are met:

- The recipient is a woman between the ages of 12 and 60.
- Wisconsin Medicaid receives a medical or pharmacy claim for the recipient that indicates a pregnancy using the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM).
- A pharmacy claim for a drug that possesses a clinical significance of D, X, or 1 (as assigned by the Food and Drug Administration [FDA] or First DataBank, Inc.) is submitted for the recipient.

Codes D, X, and 1 are defined as follows:

D: There is positive evidence of human fetal risk based on adverse reaction data from investigational or marketing experience or studies in humans. However, potential benefits may warrant use of the drug in pregnant women despite potential risks if the drug is needed in a life-threatening situation or for a serious disease for which safer drugs cannot be used or are ineffective. This is an FDA-assigned value.

X: Studies in animals or humans have demonstrated fetal abnormalities and/or there is positive evidence of human fetal risk based on adverse reaction data from investigational or marketing experience, and the risks involved in use of the drug in pregnant women clearly outweigh potential benefits. This is an FDA-assigned value.

1: No FDA rating but is contraindicated or not recommended; may have animal and/or human studies or pre- or post-marketing information. This is a First DataBank, Inc.-assigned value.

Wisconsin Medicaid will deactivate the pregnancy diagnosis from the recipient's medical profile after 260 days or if an intervening diagnosis indicating delivery or other pregnancy termination is received on a claim.

Wisconsin Medicaid will deactivate the pregnancy diagnosis from the recipient's medical profile after 260 days or if an intervening diagnosis indicating delivery or other pregnancy termination is received on a claim.

Early Refill

Wisconsin Medicaid activates this alert when a recipient is requesting a refill of his or her prescription early. The alert is sent to the provider if a claim is submitted before 75% of the previous claim's days' supply for a drug should have been used. The alert gives the number of days' that should remain on the prescription, not the day that the drug can be refilled without activating the alert. Drugs with up to a 10-days supply are excluded from this alert. Wisconsin Medicaid monitors a

comprehensive list of drug categories that excludes antibiotics, insulins, IV solutions, electrolytes except potassium, blood components and factors, and diagnostic drugs.

Additive Toxicity

Wisconsin Medicaid activates this alert when a prescribed drug causes a cumulative effect with other drugs in the claims history. Points accumulate for side effects based on the severity and the frequency of the side effect. Once a defined threshold is reached, the alert is sent to the provider.

Wisconsin Medicaid uses National Council for Prescription Drug Programs (NCPDP) field 526 (Additional Message Information) to provide pharmacy providers with additional drug history information when the additive toxicity alert is activated. Up to six drugs from the history that activated the alert are displayed in this field.

Drug-Age Precaution (Pediatric)

Wisconsin Medicaid activates this alert when a prescription drug should not be dispensed to the recipient because of age precautions specific to the drug. This alert only applies to recipients who are 18 years old or less.

Late Refill

Wisconsin Medicaid activates this alert when a recipient is late in obtaining a refill for maintenance drugs such as those listed below. The alert is sent to the provider when a drug is refilled and it exceeds 125% of the days' supply on the same drug in history. The number of days' late is calculated as the days after the prescription should have been refilled. Drugs with up to a 10-days supply are excluded from this alert. This alert applies to, but is not limited to, the following therapeutic categories:

- Angiotensin converting enzyme inhibitors.
- Alpha-blockers.
- Antilipidemics.
- Angiotensin-2 receptor antagonists.
- Anti-arrhythmics.
- Anticonvulsants.
- Antidepressants.
- Antipsychotics.
- Beta-blockers.
- Calcium channel blockers.
- Digoxin.
- Diuretics.
- Oral hypoglycemics.

National Council For Prescription Drug Programs Fields That Display Alert Information

Fields Required to Respond to Alerts and Receive Reimbursement

The provider is required to respond to the alert to obtain reimbursement from Wisconsin Medicaid. To respond, providers need to have access to all prospective DUR database fields within the NCPDP Telecommunication Standards 3C, 3.2 variable, or 4.0 variable formats (as of September 1999). The required fields are listed in Appendix 1 of this section. Providers are strongly encouraged to contact their software vendors to ensure that they have access to these fields.

The provider is required to respond to the alert to obtain reimbursement from Wisconsin Medicaid.

Using the fields listed in Appendix 1 of this section, providers can also pre-override anticipated alerts. Wisconsin Medicaid prospective DUR allows pre-overrides if the drug in claims history that would activate an alert was dispensed from the same pharmacy.

Fields 439 (conflict code), 544 (free text), and 535 (overflow indicator)

Prospective DUR alerts are returned to pharmacy providers as a conflict code, which is NCPDP field 439. The explanation of the alert is in NCPDP field 544. When more than three alerts are activated by one claim, the system indicates this in NCPDP field 535, the DUR overflow indicator. Providers will need to call Medicaid Provider Services at (800) 947-9627 or (608) 221-9883 to find out additional alert information.

Refer to Appendix 2 of this section for a chart listing the conflict names, codes, and messages for each of the prospective DUR alerts.

Edits, Audits, and Alerts

The claims processing system includes certain edits and audits. Edits check the validity of data on each individual claim. For example, a claim with an invalid NDC will be denied with an edit. In contrast, audits review claim history: if the same claim is filed at two different pharmacies on the same day, for example, the claim at the second pharmacy will be denied with an audit.

Responding to DUR alerts is not considered a Pharmaceutical Care (PC) service.

Only payable claims that are not denied by an edit or audit are submitted to prospective DUR. Prospective DUR alerts inform providers of potential drug therapy problems. Providers can override any of these alerts.

Prospective Drug Utilization Review and Pharmaceutical Care

Responding to DUR alerts is not considered a Pharmaceutical Care (PC) service. Not all PC services for which a provider receives a DUR alert are reimbursable under the PC benefit. Refer to Appendix 9 of this section for a description of minimum standards for submitting PC claims and to the "Pharmaceutical Care" chapter of this section for further PC information.

Pharmaceutical Care services can be billed through real-time POS or by using the paper non-compound drug claim form indicating PC codes in the three fields shared with DUR and the level of service field. Wisconsin Medicaid reminds providers that there are limitations on PC billing and reimbursement.

Retrospective Drug Utilization Review

Retrospective Drug Utilization Review Activities

Retrospective DUR reviews are performed by Wisconsin Medicaid on a monthly basis. Review of drug claims against DUR Board-approved criteria generate patient profiles that are individually reviewed for clinical significance.

Each month, all Medicaid fee-for-service pharmacy claims are examined by a software program for potential adverse drug concerns. Among the problems reviewed are drug/drug interactions, overuse (early refill), drug/disease contraindication, duplicate therapy, high dose, and drug pregnancy contraindication.

If a potential drug problem is discovered, intervention letters are sent to all providers who ordered a drug relevant to the identified problem. Criteria are developed by Wisconsin Medicaid and are reviewed and approved by the DUR Board. An intervention consists of an informational letter to the prescriber, a response form for the prescriber to complete, a pre-addressed return envelope, and a patient drug profile.

On average, 2,200 intervention letters are sent each year. Intervention letters include a questionnaire about prescriber action. The average questionnaire response rate has been 67%, and approximately 75% of prescribers who respond to how useful the intervention was indicate it was useful or very useful.

Recipient Lock-In Program and Retrospective Drug Utilization Review

The purpose of the recipient lock-in program (RLP) is to coordinate the provision of health care services for recipients who abuse or misuse Medicaid benefits by seeking duplicate or medically unnecessary services.

Coordination of recipient health care services is intended to:

- Curb the abuse/misuse of controlled substance medications.
- Improve the quality of care for the recipient.
- Reduce unnecessary physician utilization.

With these goals in mind, ensuring necessary access to necessary Medicaid services remains a priority.

The Wisconsin Medicaid RLP focuses on the abuse/misuse of controlled substance medications. Abuse or misuse is defined under "Recipient Duties" in HFS 104.02, Wis. Admin. Code. These duties include:

- Not to duplicate or alter prescriptions.
- Not to feign illness, use false pretense, provide incorrect eligibility status, or provide false information to obtain service.
- Not to seek duplicate care from more than one provider for the same or similar condition.
- Not to seek medical care which is excessive or not medically necessary.

Referrals of recipients as candidates for lock-in are received from retrospective DUR, physicians, pharmacists, other types of providers, and through automated surveillance methods. Once a referral is received, six months of pharmacy claims and diagnoses data are reviewed by a pharmacist. A recommendation for one of the following courses of action is then made:

- Enroll in the RLP.
- Send an intervention letter to the physician.
- Send a warning letter to the recipient.
- No further action.

Wisconsin Medicaid recipients who are candidates for enrollment in the RLP are sent a letter of intent, which explains the restriction that will be applied, how to designate a physician and a pharmacy, and how to request a hearing if they wish to contest the decision for enrollment. If recipients fail to designate providers, the RLP may assign providers based on claims' history. Recipients are also informed that access to emergency care is not restricted.

Upon enrollment and with changes in lock-in providers, letters of notification are sent to the recipient and to the lock-in physician and pharmacy. Recipients remain in the RLP for two years. The lock-in physician and pharmacy may make referrals for specialist care or for care that they are otherwise unable to provide (e.g., home infusion services). The recipient's utilization of services is reviewed prior to release from the RLP and lock-in providers are notified of the effective date of the recipient's release.

Refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for information on RLP and emergency services, change of provider, and due process.

Designated Lock-In Pharmacies

Pharmacies designated as the lock-in pharmacy for enrolled recipients may fill prescriptions from any prescriber, including those from emergency care visits or referral physicians, as long as the prescription appears to be appropriate (e.g., it does not overlap with other prescriptions of the same drug class). For prescriptions for non-emergent care, the pharmacist may call the lock-in physician as identified in the most current letter of notification or the RLP to ascertain whether or not a referral is in place for the provider issuing the prescription.

The Wisconsin Medicaid RLP focuses on the abuse/misuse of controlled substance medications.

Educational Program

A number of educational programs are generated by the DUR program. One of the primary means of education is the distribution of educational newsletters to prescribers and pharmacists. Topics for newsletters have included:

- Current treatment protocols.
- How to best use the information received in the intervention letter.
- New drug/drug interactions.
- Utilization and cost data for selected therapeutic classes of drugs.
- Comparison of efficacy and cost of drugs within a therapeutic class.

In addition, the intervention letters sent out generate additional calls to the DUR pharmacy staff that provide an opportunity for a one-to-one educational activity with the prescriber.

Pharmaceutical Care

Pharmaceutical Care is a nationwide movement promoting a patient-centered, outcomes-oriented practice of pharmacy. Its purpose is to maximize the effectiveness of medications for the patient through intervention by the pharmacist.

Under 1995 Wisconsin Act 27, the state biennial budget, Wisconsin Medicaid was required to develop an incentive-based pharmacy payment system that pays for Pharmaceutical Care (PC) services.

Pharmaceutical Care is a nationwide movement promoting a patient-centered, outcomes-oriented practice of pharmacy. Its purpose is to maximize the effectiveness of medications for the patient through intervention by the pharmacist.

Wisconsin Medicaid's PC program provides pharmacists with an enhanced dispensing fee for PC services given to Wisconsin Medicaid fee-for-service recipients. This enhanced fee reimburses pharmacists for additional actions they take beyond the standard dispensing and counseling for a prescription drug.

For recipients enrolled in a Medicaid managed care program, each program develops its own policy regarding drug prices, dispensing fees, and whether to pay for PC services. Providers should contact the recipient's managed care program for further information.

Documentation

Pharmaceutical Care Profile

A PC profile must be created and maintained for the recipient prior to submitting a PC claim. It must include the intended use or diagnosis information for each drug the recipient is actively using. The source of information and level of confidence must be documented. To facilitate a more thorough understanding of the recipient's medical condition(s), inclusion of the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) codes for each diagnosis or intended use is recommended. Refer to Appendix 4 of this section for PC profile requirements.

Documentation Form For Pharmaceutical Care

The required, retrievable information for PC documentation can be found in Appendix 5 of this section. Providers may use any format to document PC, but that format must include all the elements in the model form provided in Appendix 5 of this section.

ICD-9-CM Coding Requirements

Valid ICD-9-CM codes are required on the drug claim for each PC intervention submitted. Providers must make a reasonable effort to report an ICD-9-CM code that identifies the medical condition most closely related to the PC intervention performed. This is generally the ICD-9-CM code associated with the drug dispensed as a result of the intervention.

The diagnosis and associated ICD-9-CM code should be determined and reported to the level of specificity the provider believes is necessary to perform the intervention. This could be three, four, or five digits. In some situations a general knowledge of the disease state(s) is necessary and in others a more precise determination is necessary to determine if an intervention is appropriate.

For example, knowledge of a general medical condition may be sufficient to determine that multiple non-steroidal anti-inflammatory drug use is probably not appropriate. However, in other situations the precise diagnosis must be known to determine if a specific drug's dosage level is too high or too low.

Pharmaceutical Care Dispensing Fee

Reimbursement for the PC dispensing fee requires the pharmacist to meet all basic requirements of federal and state law for dispensing a drug plus completing specified activities that result in a positive outcome both

for the recipients and the Wisconsin Medicaid program. Some positive outcomes include increasing patient compliance or preventing potential adverse drug reactions.

Reimbursement is based on the following:

- The *reason* for intervention.
- The *action* taken by the pharmacist.
- The *result* of that action.
- The time spent performing the activity.

Appendices 6 through 8 of this section provide tables showing allowed combinations of reason, action, and result codes. Billing limitations for PC codes include the following:

- Wisconsin Medicaid will only reimburse for one PC dispensing fee per recipient per provider per day.
- Some codes have a maximum billing frequency allowed. Refer to Appendix 7 of this section for a complete list of these limits.
- Allowable codes have maximum allowed reimbursement levels.
- Pharmaceutical Care is not billable for compound drugs.
- Certain codes are not billable for nursing facility recipients.

Wisconsin Medicaid requires providers to bill their usual and customary charges for this service. Providers should maintain documentation of their usual and customary charges.

Professional Pharmaceutical Care Intervention Time

Professional PC intervention time includes the following:

- Time spent resolving a specific drug therapy problem.
- Time spent communicating with the prescriber about a specific patient problem and its definition and/or resolution.
- Time spent communicating with the patient or agent of the patient about a specific therapeutic problem including its definition and/or resolution.
- Time spent resolving problems identified during drug regimen reviews (DRR) for nursing home residents when performed at a level greater than DRR requirements and not compensated for under DRR payments from the facility.

The following situations are not included in the intervention time:

- Time spent researching a drug therapy problem, including reviewing medical literature or peer-reviewed literature.
- Time spent consulting with another professional regarding a therapy problem such as another pharmacist, medical professional, or poison center.
- Time spent in continuing education classes.
- Time spent reviewing PC profiles for drug therapy problems.
- Time spent performing DRRs and documenting irregularities for nursing home residents.

Wisconsin Medicaid will only reimburse for one PC dispensing fee per recipient per provider per day.

Pharmaceutical Care Billing Requirements and Claims Processing Limits

Only one PC dispensing fee is payable per date of service.

In most cases, payments using PC dispensing fees are limited to one, two, or four fees per year, per recipient, per pharmacy. See Appendix 8 of this section for specific limits.

The PC dispensing fee includes all pharmacy services reimbursement, except drug cost, for *one* dispensed or prescribed drug associated with the PC intervention.

There is no separate or additional reimbursement for compounding or dispensing the drug paired with the PC intervention on the drug claim.

Submitting Claims For Pharmaceutical Care Dispensing Fee

Providers may submit claims for PC services as real-time claims or by using the non-compound drug claim form using PC codes in the three fields shared with drug utilization review (DUR). These codes follow National Council for Prescription Drug Program format. Claims for PC cannot be submitted through electronic media claims.

Providers may submit claims for PC services as real-time claims or by using the non-compound drug claim form using PC codes in the three fields shared with drug utilization review (DUR).

In real-time or paper claims submission, the provider should determine the total billing amount by adding together the usual and customary fee for the drug charge and the usual and customary fee for PC. (Level of service [LOS] is included in PC.)

Pharmaceutical Care claims submission requires an ICD-9-CM valid diagnosis code. If the diagnosis field is left blank, the PC claim will be denied.

To submit claims for PC:

- Enter the appropriate Reason code in the DUR conflict field. (Refer to Appendix 6 of this section for a list of reason codes.)
- Enter the appropriate Action code in the DUR intervention field. (Refer to Appendix 6 of this section.)
- Enter the appropriate Result code in the DUR outcome field. (Refer to Appendix 6 of this section.)
- Enter the appropriate LOS in the level of service field. (Refer to Appendix 9 of this section.)
- Enter a valid value in the unit dose (UD) field.
- Include the usual and customary charge for the PC in the "Billed Amount" field along with the usual and customary charge for the drug.

Refer to the Claims Submission section of this handbook for further claims submission instructions.

If a drug is not dispensed, but a PC service is provided for a Medicaid-covered and payable drug, then the PC may be reimbursed. Submit the claim for the PC in the following way:

- Use the National Drug Code of the drug that was not dispensed.
- Enter "0" as the quantity and the PC fee as the charge.
- Enter the appropriate PC information as instructed earlier.
- Enter "0" (traditional packaging) or "2" (UD packaging) in the UD field. These are the only acceptable values when no drug has been dispensed.
- Enter the number in the days supply field that reflects the amount that would have been dispensed.

The Medicaid-specific PC codes may be submitted as a real-time claim if your software and switch vendor will allow it. If not, the claim can be submitted on the paper non-compound drug claim form.

A Medicaid-payable drug will be paid even if the PC code is billed incorrectly. However, the traditional dispensing fee will not be substituted when the PC code is denied.

Responses to prospective DUR alerts will not necessarily qualify as PC services. Refer to Appendix 9 of this section for a description of minimum standards for billing PC. Services covered under the traditional Medicaid dispensing fee include record keeping, patient profile preparation, prospective DUR, and counseling.

Refer to the "Drug Utilization Review" chapter and Appendices 1-3 of this section for information on the prospective DUR system, including billing codes and alert information.

Appendix

Appendix 1

National Council For Prescription Drug Programs Fields Needed For Prospective Drug Utilization Review

The following table lists the National Council for Prescription Drug Programs (NCPDP) fields a provider is required to respond to in order to obtain reimbursement from Wisconsin Medicaid. Providers are strongly encouraged to contact their software vendors to ensure that they have access to these fields.

Action	NCPDP Field Number	Field Name	Description
Submitting claims	418	Level of Service	Only needed for compounding and Pharmaceutical Care reimbursement.
	439	DUR Conflict Code	DD = Drug-Drug MC = Drug-Disease (Reported) DC = Drug-Disease (Inferred) TD = Therapeutic Duplication PG = Drug-Pregnancy ER = Overutilization AT = Additive Toxicity PA = Drug-Age LR = Underutilization
	440	DUR Intervention Code	Refer to Appendix 3 of this section
	441	DUR Outcome Code	Refer to Appendix 3 of this section
Receiving responses Up to three alerts may be received.	439	DUR Conflict Code	See 439 above
	526	Additional Message Information	Use to supply information pertaining to the Additive Toxicity (AT) alert
	528	Clinical Significance Code	1 = Major 2 = Moderate 3 = Minor
	529	Other Pharmacy Indicator	0 = Alert set is based on current claim only 1 = Your pharmacy 3 = Other pharmacy
	530	Previous Date of Fill	YYYYMMDD = This field is zero-filled if the alert is set based on data on the current claim only. Otherwise it contains the Date of Service from the other claim or history claim causing the alert to set.
	531	Quantity of Previous Fill	999.99 = This field is zero-filled if the alert is set based on data on the current claim only. Also zero-filled when the other claim or profile record causing the alert to set has spaces in the quantity field. Otherwise, contains the quantity from the other claim or history claim.
	532	Database Indicator	1 = FDB
	533	Other Prescriber Indicator	0 = Not specified 1 = Same prescriber 2 = Other prescriber
	535	DUR Overflow Indicator	0 = Not specified 2 = More than 3 alerts
	544	Free Text	DUR alert message

Appendix 2

Conflict Names, Codes, and Explanations For Each of the Prospective Drug Utilization Review Alerts

The table below lists the conflict names, codes, and messages for each of the prospective Drug Utilization Review (DUR) alerts. Providers will need to call Medicaid Provider Services at (800) 947-9627 or (608) 221-9883 to find out additional alert information.

Conflict Name	Confilict Code	Message displayed in NCPDP Field 544 (Free text)
Drug-drug interaction	DD	"<Brand name of drug in history causing alert>"
Drug-disease contraindication (reported)	MC	"<Disease description of contraindication>"
Drug-disease contraindication (inferred)	DC	"<Disease description of contraindication>"
Therapeutic duplication	TD	"<Name of most recent history drug - trade or generic>"
Pregnancy alert	PG	"Pregnancy contraindication"
Early refill	ER	"XX days of prescription remaining"
Additive toxicity	AT	"Side effect"
Drug-age precaution (pediatric)	PA	"Age warning/contraindication"
Late refill	LR	"Refill is XX days late"

Appendix 3
Drug Utilization Review Service Codes

Table One: Drug Utilization Review (DUR) Reason for Service Codes

DOSING/LIMITS	DRUG CONFLICT
ER Overuse	AT Additive Toxicity
LR Underuse	DC Drug-Disease (Inferred)
	DC Drug-Drug Interaction
	MC Drug-Disease (Reported)
	PA Drug-Age
	PG Drug-Pregnancy
	TD Therapeutic Duplication

Table Two: DUR Action for Service Codes

Administrative		Patient Care	
00	No Intervention	AS	Patient Assessment
FE	Formulary Enforcement	CC	Coordination of Care
GP	Generic Product Selection	M0	Prescriber Consulted
PH	Patient Medication History	MR	Medication Review
TC	Payer/Processor Consulted	P0	Patient Consulted
TH	Therapeutic Product Interchange	PE	Patient Education/Instruction
SW	Literature Search/Review	PF	Patient Referral
		PM	Patient Monitoring
		PT	Perform Laboratory Test
		R0	Pharmacist Consulted Other Source
		RT	Recommended Laboratory Test
		SC	Self-Care Consultation

Table Three: Result of Service Codes

Dispensed		Not Dispensed		Patient Care	
00	Not Specified	2A	Prescription Not Filled	3A	Recommendation Accepted
1A	Filled as is, False Positive Clarified	2B	Not Filled, Directions Clarified	3B	Recommendation Not Accepted Clarified
1B	Filled Prescription as is			3C	Discontinued Drug
1C	Filled, With Different Dose			3D	Regimen Changed
1D	Filled, With Different Directions			3E	Therapy Changed
1E	Filled, With Different Drug Acknowledged			3F	Therapy Changed, Cost Increase Acknowledged
1F	Filled With Different Quantity			3G	Drug Therapy Unchanged
1G	Filled, With Prescriber			3H	Follow-Up Report
1H	Brand-to-Generic Change				
1J	Rx-to-OTC Change				

Outcome codes that begin with '1' indicate that dispensing ultimately did occur. Outcome codes that begin with '2' indicate that dispensing was avoided. Outcome codes that begin with "3," or patient care types of results of service codes, may or may not be involved with the dispensing of a medication.

Appendix 4

Wisconsin Medicaid Pharmaceutical Care Profile

The recipient Pharmaceutical Care (PC) profile establishes a basis for all PC activities provided. As part of the PC profile, the pharmacist must certify that sufficient clinical information has been collected and documented about the recipient so clinically relevant PC interventions are possible. This includes his or her disease state(s), diagnosis(es), or intended use(s) for each over-the-counter and legend drug(s) the recipient is actively using.

A PC profile must contain all information required under Pharmacy Examining Board and Medicaid rules. In addition, a face-to-face recipient interview and medication work-up must be completed by a pharmacist. Providers must know and document the basis for the recipient's complete medication therapy regimen. Each provider must adopt and use a clinically oriented standard interview and work-up form and process.

Clinical information may be obtained from the recipient, agent of the recipient, prescriber, or any combination of the three. For recipients in a health care facility, information may be obtained from recipient records and prescriber orders via facility staff. The pharmacist should document the source (physician, recipient, inferred, etc.) and reliability (high, somewhat, questionable, etc.) of the information for future users. The pharmacist is required to determine the intended use or target disease state for each drug listed on the profile.

The pharmacist must determine that sufficient clinical information has been gathered and documented. Lack of sufficient clinical information about the recipient and his or her medical condition precludes reimbursing PC dispensing fees.

Documentation Requirements

The following documentation must be retrievable and must be provided if requested by Wisconsin Medicaid. Failure to provide this documentation may result in recoupment of the PC dispensing fee:

- A recipient profile which meets the Pharmacy Examining Board, prospective Drug Utilization Review, and Medicaid requirements.
- Results from the recipient interview and medication work-up.
- Recipient-specific diagnoses, disease state, or intended use for each drug.
- Date PC profile was created (may be different from date on first PC claim).
- Identification of the pharmacist doing the medication history and profile preparation.
- Source and reliability of clinical information collected for the profile.
- Recommendations, plans, PC needs of the recipient, etc., if any.
- Information about each PC intervention attempted and completed.

Additional Discussion

Each PC profile must contain sufficient clinical information about the recipient to make relevant clinical decisions and recommendations. All PC profile information must be immediately available to the pharmacist and must be reviewed and updated each time a prescription is filled for the recipient.

Appendix 5

Wisconsin Medicaid Pharmaceutical Care Dispensing Fee Documentation

See reverse side of this page for the optional form that may be used to provide the required, retrievable information for the Pharmaceutical Care dispensing fee.

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Wisconsin Medicaid Pharmaceutical Care Dispensing Fee Documentation

Providers may use any format to document Pharmaceutical Care (PC), but that format must include all the same information as this form.

Patient Name:_____ Medicaid ID No.:_____

Pharmacy Name:_____ Medicaid Provider ID No.:_____

You must establish and document your usual and customary fee structure for PC services billed to non-Medicaid patients.

Indicate your usual and customary non-Medicaid charge for this PC service.

PC Code: _____ **U/C Charge:** _____ **Date PC Completed:** _____

Reason: Provide details about the intervention. Describe problem(s) and rationale or basis for initiating intervention. Include all drugs, DUR alerts, or problems encountered when attempting to dispense the prescription. Document assessment and plan for care.

Action: Provide details about specific action(s) performed to resolve the problem(s), including identification of all contacts.

Result: Provide details about the outcome of the intervention.

Level Prof. Intervention Time:_____ minutes (exclude doc time)
Documentation Time:_____ minutes

Pharmacist's Name: _____

List prescribed drug(s) involved in intervention (include discontinued or unfilled prescriptions).

Drug Name and Strength	Quantity	Refills	ICD-9-CM	Filled-Yes/No

If the PC Result code is 1C, 1D, 1E, 1F, 1K, or 2A, complete the following:

Check all that apply:

___ Changed dose (before/after) _____ ___Changed quantity (before/after) _____
___ Changed frequency (before/after)_____ ___Changed directions (before/after) _____
___ Discontinued or not-filled order _____ ___Other charge, specify _____

List additional service(s), if any, resulting from this PC intervention, e.g. new drug(s), lab service, M.D. office visit, etc.

Appendix 6

Wisconsin Medicaid Pharmaceutical Care Worksheet for Payable Codes

Providers may use the following tables to assist in determining billing codes for Pharmaceutical Care (PC) dispensing fees. Not all code combinations are recognized as PC activities and not all recognized PC activities result in allowable PC dispensing fees. Pharmaceutical Care codes are only billable when they represent activity beyond that required under Omnibus Budget Reconciliation Act of 1987 (OBRA '87) and OBRA '90 and when they deal with issues of patient compliance, safety, or efficacy that result in a positive outcome.

Reason for provision of Pharmaceutical Care

☐	AD	(60)	Additional Drug Recommended		
☐	AN	(10)	Forgery Possible (Prescription Authentication) √		
☐	AR	(61)	Adverse Drug Reaction √		
☐	AT	(40)	Additive Toxicity		
☐	CD	(71)	Chronic Disease Mgt - Asthma		
☐	CS	(63)	Patient Complaint/ Symptom		
☐	DA	(41)	Drug Allergy		
☐	DD	(44)	Drug-Drug Interaction		
☐	DI	(45)	IV Drug Incompatibility		
☐	DM	(65)	Possible Drug Misuse √		
☐	ER	(20)	Early Refill √		
☐	EX	(21)	Excessive Quantity		
☐	HD	(23)	High Dose		
☐	LD	(33)	Low Dose		
☐	LK	(66)	Lock-in Recipient √		
☐	LR	(25)	Late Refill (Under Use) √		
☐	MN	(30)	Insufficient Duration		
☐	MX	(22)	Excessive Duration √		
☐	NN	(80)	Unnecessary Drug √		
☐	NS	(32)	Insufficient Quantity		
☐	PS	(17)	Product Selection Opportunity		
☐	RE	(84)	Suspected Environmental Risk (In-home Management)		
☐	SC	(83)	Suboptimal Compliance		
☐	SE	(95)	Side-Effect Precaution (Side Effect) √		
☐	SF	(34)	Suboptimal Dose Form		
☐	SR	(36)	Suboptimal Regimen		
☐	TD	(59)	Therapeutic Duplication		
☐	TN	(85)	Lab Test Needed √		
☐		√	**Not Billable For Nursing Home Residents**		

Action taken by pharmacist

☐	AS	(20)	Patient Assessment		
☐	CC	(21)	Coordination of Care		
☐	M0	(22)	MD Contacted (Prescriber Consulted)		
☐	MR	(23)	Medication Review		
☐	PE	(25)	Patient Education		
☐	R0	(29)	R.Ph. Consult Other Contacted		
☐	RT	(30)	Recommend Lab Test		
☐	TC	(15)	Payer/Processor Contacted		
☐	TH	(12)	Therapeutic Product Interchange* *** Action Requires Prescriber Authorization**		

Result of action

☐	1C	(12)	Filled, Different Dose		
☐	1D	(13)	Filled, Different Directions		
☐	1E	(14)	Filled, Different Drug		
☐	1F	(15)	Filled, Different Quantity		
☐	1K	(18)	Filled, Dose Form Change		
☐	2A	(30)	NOT Filled		
☐	3K	(85)	Instructions Understood		
☐	3M	(80)	Compliance Aid Developed (Distribution System)		

Level

☐	11	0 through 5 minutes
☐	12	6 through 15 minutes
☐	13	16 through 30 minutes
☐	14	31 through 60 minutes
☐	15	61+ minutes

Use alphanumeric values for real-time and paper claims. Pharmaceutical Care cannot be billed through electronic media claims.

Appendix 7

Wisconsin Medicaid Pharmaceutical Care Reason Codes With Billing Information

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, Pharmaceutical Care (PC) Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
AD (60) — Based on review of the recipient's drug regimen, the pharmacist-determined treatment may be enhanced by addition of a new drug to the existing drug regimen.	M0 (22) — Prescriber contacted.	1E (14) — Order filled with different drug.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: AD-M0-1E+ + Requires linked drug National Drug Code (NDC), same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Nature of problem that additional drug may correct. • Summary of and basis for recommendation(s). • Outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of 2 Reason AD (60) PC dispensing fees per recipient, per year. • Level 13 = maximum PC dispensing fee.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
AN (10) — Prescription order forgery suspected.	M0 (22) — Prescriber contacted. R0 (29) — Pharmacist contacted other source or contact (e.g., police or another pharmacy). TC (15) — Payer/processor contacted. To submit Action code R0, prescriber must be contacted and concur that the prescription order should not be filled.	2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$40.11 15-$40.11 ——————— Allowed PC dispensing fee code combinations: AN-M0-2A AN-R0-2A AN-TC-2A	Document: • Date of intervention. • List prescription (Rx) orders questioned. Include drug, quantity, directions, and prescriber name. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Basis for suspicion of forgery. • Summary of any communication with prescriber, recipient, or other contact. • Changes made to drug(s), dose, frequency, directions, or quantity prescribed. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • Prescriber contact required for PC dispensing fee. • No more than two Reason (10) PC dispensing fees per recipient per year. • Level 14 = maximum PC dispensing fee. • Not billable for nursing home residents.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
AR (61) — Based on information obtained about the recipient's medical condition, the pharmacist has determined the recipient may be experiencing an adverse drug reaction.	M0 (22) — Prescriber contacted.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: AR-M0-1C+ AR-M0-1D+ AR-M0-1E+ AR-M0-1K+ AR-M0-2A + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Nature of adverse reaction. • Identify drug(s) involved. • Summary of and therapeutic basis for recommendation(s). • Outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason AR (61) PC dispensing fees per recipient, per year. • Result Code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Not billable for nursing home residents. • Level 13 = maximum PC dispensing fee.

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
AT (40) — Recipient's drug regimen includes multiple drugs that may cause additive toxicity or side effects according to medical literature.	M0 (22) — Prescriber contacted. RT (30) — Pharmacist recommended lab test to the physician.	1C (12) — Order filled with a different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with a different drug. 1F (15) — Order filled with different quantity. 1K (18) — Order filled with a different dosage form. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: AT-M0-1C+ AT-M0-1D+ AT-M0-1E+ AT-M0-1F+ AT-M0-1K+ AT-M0-2A AT-RT-1C+ AT-RT-1D+ AT-RT-1E+ AT-RT-1F+ AT-RT-1K+ AT-RT-2A + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Nature of problem caused by multiple drugs. • Identify drugs. • Summary of and basis for recommendation(s). • Outcome including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason AT (40) PC dispensing fees per recipient, per drug combination, per year. • Result code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Level 13 = maximum PC dispensing fee.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
CD (71) — New diagnosis or new drug therapy — ASTHMA. The pharmacist has determined that additional education or counseling is necessary.	M0 (22) — Prescriber contacted. PE (25) — Verbal or written communication to the recipient by a pharmacist to enhance the recipient's knowledge about the condition under treatment, or to develop skills and competencies related to its management.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled. 3M (80) — Compliance aid developed. 3K (85) — Recipient understands.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$40.11 15-$40.11 Allowed PC dispensing fee code combinations: CD-M0-1C+ CD-M0-1D+ CD-M0-1E+ CD-M0-1K+ CD-M0-2A CD-PE-3M+ CD-PE-3K+ + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Verify new diagnosis. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify new drug therapy. • Summary of information or education provided in each session. • Prepare and maintain a therapeutic work-up and report to be made available to the prescriber on request. • Pharmacist helped the recipient understand all recipient-specific, drug-related problems. • Desired therapeutic outcome(s) expected. • Plan for monitoring the recipient. • R.Ph. identity. Limits: • A maximum of six Reason CD (71) PC dispensing fees per recipient, per year. • Level 14 is maximum PC dispensing fee.

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
CS (63) — Based on recipient complaint or known or suspected symptom(s), the pharmacist initiated drug regimen review or recipient consultation. The pharmacist determined an actual or potential medical problem, other than adverse drug reaction, may exist.	AS (20) — Evaluation of information known by the pharmacist or supplied by the recipient for the purpose of developing a problem-based therapeutic plan. M0 (22) — Prescriber contacted.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled. 3K (85) — Instructions understood.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: CS-AS-3K+ CS-M0-1C+ CS-M0-1D+ CS-M0-1E+ CS-M0-1K+ CS-M0-2A + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Recipient complaints or symptom(s). • Process, including medical literature, used to determine actual or potential problem. • Description of therapeutic basis for the possible problem. • Summary of outcome, including summary of any communication, with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of one Reason CS (63) PC dispensing fee per recipient, per year. • Result code 2A (30) may only be indicated when a replacement drug is *not* prescribed • Level 13 = maximum PC dispensing fee. Notes: Rule out use of other PC Reason Codes which may be more specific to the problem before using this code.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
DA (41) — Recipient has a known or suspected allergy to this drug or drug with similar pharmacological effects resulted in atypical reactions.	M0 (22) — Prescriber contacted.	1E (14) — Order filled with different drug. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: DA-M0-1E+ DA-M0-2A + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Nature of allergy problem. • Identify drug. • Summary of and basis for recommendation(s). • Outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason DA (41) PC dispensing fees per recipient, per drug, per year. • Result code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Level 13 = maximum PC dispensing fee.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
DD (44) — Recipient's drug regimen includes multiple drugs which may result in unintended pharmacological response according to medical literature.	M0 (22) — Prescriber contacted.	1C (12) — Order filled with a different dose. 1E (14) — Order filled with different drug. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: DD-M0-1C+ DD-M0-1E+ DD-M0-2A + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug(s). • Nature of problem caused by multiple drugs. • Summary of and basis for recommendation(s). • Outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason DD (44) PC dispensing fees per recipient, per drug combination, per year. • Result Code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Level 13 = maximum PC dispensing fee.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
DI (45) — IV drug incompatibility detected.	M0 (22) — Prescriber contacted.	1E (14) — Order filled with different drug. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: DI-M0-1E+ DI-M0-2A + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Nature of compatibility problem. • Summary of and basis for recommendation(s). • Outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason DI (45) PC dispensing fees per recipient, per drug, per year. • Result code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Level 13 = maximum PC dispensing fee.

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
DM (65) — Possible drug misuse.	M0 (22) — Prescriber contacted.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1F (15) — Order filled with different quantity. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled. 3M (80) — Compliance aid developed. 3K (85) — Recipient demonstrates understanding of proper medication use.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$40.11 15-$40.11 ——————— Allowed PC dispensing fee code combinations: DM-M0-1C+ DM-M0-1D+ DM-M0-1E+ DM-M0-1F+ DM-M0-1K+ DM-M0-2A DM-M0-3M+ DM-M0-3K+ + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Description of possible problem. • Summary of outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason DM (65) PC dispensing fees per recipient, per year. • Not billable for nursing home residents. Notes: Rule out use of other PC Reason codes which may be more specific to the problem before using this code.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
ER (20) — Early refill. — Compliance problem suspected. — Refill before 75% of previous prescription should be consumed, based on predicted days supply (abuse not suspected). — Do not use this code if abuse is suspected or documented. See Reason code DM (65).	M0 (22) — Prescriber contacted. PE (25) — Verbal or written communication to the recipient by a pharmacist to enhance the recipient's knowledge, skills, and competencies.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1F (15) — Order filled with different quantity. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled. 3M (80) — Compliance aid developed. 3K (85) — Recipient demonstrates understanding of proper medication use.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: ER-M0-1C+ ER-M0-1D+ ER-M0-1F+ ER-M0-1K+ ER-M0-2A ER-PE-3M+ ER-PE-3K+ ER-PE-2A + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Dates for previous two refills. • Expected date for this refill. • Number of days early, percent early on days supply. • Determined reason for early refill request. • Outcome, including summary of any communication with prescriber and recipient. • Changes made to drug(s), dose, frequency, directions, or quantity prescribed. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. Limits: • Maximum four Reason ER (20) PC dispensing fees per recipient per year. • Result Code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • A PC dispensing fee may *not* be claimed under this code if the early refill is determined to be due to something other than a compliance problem (e.g. recipient leaving town, early refill for convenience, lost medication). • Max PC dispensing fee: Level 13 on Action code M0, level 12 on Action code PE. • Not billable for nursing facility residents.

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
EX (21) — Prescribed quantity appears excessive for the recipient's condition or predicted medical need according to medical literature (abuse not suspected).	M0 (22) — Prescriber contacted.	1C (12) — Order filled with different dose. ID (13) — Order filled with different directions. 1E (14) — Filled, different drug. 1F (15) — Order filled with different quantity. 1K (18) — Filled, dose form change. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: EX-M0-1C+ EX-M0-1D+ EX-M0-1E+ EX-M0-1F+ EX-M0-1K+ EX-M0-2A + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes) • Identify drug. • Expected quantity for recipient's condition. • Determined reason for prescribed quantity. • Outcome including summary of any communication with prescriber and recipient. • Changes made to drug(s), dose, frequency, directions, or quantity prescribed. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • Prescriber contact required. • Maximum of two Reason EX (21) PC dispensing fees per recipient, per drug, per year. • Do not use this code if abuse is suspected or documented. See Reason Code DM (65). • Result Code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Level 13 = maximum PC dispensing fee. Notes: Titration or other dose adjustment must first be ruled out.

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
HD (23) — Prescribed dose is above the standard range for patient's condition according to the literature (abuse not suspected).	M0 (22) — Prescriber contacted.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: HD-M0-1C+ HD-M0-1D+ HD-M0-1E+ HD-M0-1K+ HD-M0-2A + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason HD (23) PC dispensing fees per recipient per year. • Do not use this code if abuse is suspected or documented, see Reason code DM (65). • Result code 2A (30) may only be used when a replacement drug is *not* prescribed. • Level 13 = maximum PC dispensing fee.

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
LD (33) — Prescribed dose may be insufficient to treat this recipient's medical condition according to medical literature. — Titration ruled out.	M0 (22) — Prescriber contacted.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1F (15) — Order filled with different quantity. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: LD-M0-1C+ LD-M0-1D+ LD-M0-1E+ LD-M0-1F+ LD-M0-1K+ LD-M0-2A + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Minimum expected dose. • Source of minimum recommendation. • Outcome including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason LD (33) PC dispensing fees per recipient per drug per year. • A Reason LD (33) PC dispensing fee may not be claimed if titration is determined to be the basis for the "insufficient" dose. • Level 13 = maximum PC dispensing fee.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
LK (66) — Patient has been selected by the Medicaid Program to be locked-in to a physician and/or pharmacist based on information known about the patient's medical condition and use of excessive medication in a manner that may indicate drug abuse or diversion.	CC (21) — Pharmacist initiated contact with multiple prescribers to facilitate coordination of care. M0 (22) — Prescriber contacted. PE (25) — Verbal or written communication with patient by a pharmacist to instruct patient in appropriate drug use. TC (15) — Pharmacist communicated with claims processor or state Medicaid program staff.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1F (15) — Order filled with different quantity. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled. 3K (85) — Instructions understood.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$40.11 15-$40.11 ——————— Allowed PC dispensing fee code combinations: LK-CC-1C LK-CC-1D LK-CC-1E LK-CC-1F LK-CC-1K LK-CC-2A LK-CC-3K LK-M0-1C LK-M0-1D LK-M0-1E LK-M0-1F LK-M0-1K LK-M0-2A LK-M0-3K LK-PE-2A LK-PE-3K LK-TC-2A LK-TC-3K	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Description of possible problem. • Name of person(s) contacted. • Summary of outcome, including summary of any communication with prescriber(s), patient, and other contact(s) . • Indicate if intervention was for safety, efficacy, compliance or cost savings-only purposes. • ICD-9-CM for diagnosis, disease or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of 15 Reason (LK) PC dispensing fees per patient per year. • This Reason code LK (66) when lock-in pharmacy manages patients enrolled in Medicaid's Recipient Lock-in Program (RLP). • Not billable for nursing home residents. • Level 14 = maximum PC dispensing fee.

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
LR (25) — Late refill requested. — Compliance problem suspected. — More than 25% after recipient should exhaust previously dispensed medication based on predicted days supply.	M0 (22) — Prescriber contacted. PE (25) — Verbal or written communication to the recipient by a pharmacist to enhance the recipient's knowledge, skills, and competencies.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1F (15) — Order filled with different quantity. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled. 3M (80) — Compliance aid developed. 3K (85) — Recipient demonstrates understanding of proper medication use.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: LR-M0-1C+ LR-M0-1D+ LR-M0-1E+ LR-M0-1F+ LR-M0-1K+ LR-M0-2A LR-PE-3M+ LR-PE-3K+ + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Dates for previous two refills. • Expected date for this refill. • Number of days late; percent late on days supply. • Determined reason for late refill. • Outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of four Reason LR (25) PC dispensing fees, per recipient, per year. • A PC dispensing fee may not be claimed under this code when the late refill is determined to be due to something other than a compliance problem (e.g., recipient had last refill filled elsewhere, previous early refill for convenience, previous lost refill found). • Do not use this code if abuse is suspected or documented. See Reason code DM (65). • Not billable for nursing home residents. • Level 13 = maximum PC dispensing fee. • Max PC dispensing fee: Level 13 on Action code M0, level 12 on Action code PE.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
MN (30) — Prescribed length of therapy may be shorter than minimum period recommended in medical literature for this recipient's condition. — Titration ruled out.	M0 (22) — Prescriber contacted.	1D (13) — Order filled with different directions. 1F (15) — Order filled with different quantity. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: MN-M0-1D+ MN-M0-1F+ MN-M0-2A + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Minimum expected length of therapy. • Source of minimum recommendation. • Outcome including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason MN (30) PC dispensing fees per recipient, per drug, per year. • A Reason MN (30) PC dispensing fee may not be claimed if titration is determined to be the basis for the short length of therapy. • Level 13 = maximum PC dispensing fee.

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
MX (22) — Prescribed length of therapy exceeds expected length of therapy for this recipient's condition according to medical literature (abuse not suspected).	M0 (22) — Prescriber contacted	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with a different drug. 1F (15) — Order filled with different quantity. 1K (18) — Order filled with a different dosage form. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: MX-M0-1C+ MX-M0-1D+ MX-M0-1E+ MX-M0-1F+ MX-M0-1K+ MX-M0-2A + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). • Time spent on documentation (minutes). • Identify drug. • Expected length of therapy. • Determined reason for prescribed length of therapy. • Outcome including summary of any communication with prescriber and recipient. • Changes made to drug(s), dose, frequency, directions, or quantity prescribed. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • Prescriber contact required. • A maximum of 2 Reason MX (22) PC dispensing fees per recipient, per drug, per year. • Do not use this code if abuse is suspected or documented. See Reason Code DM (65). • Result Code 2A (30) can only be indicated when a replacement drug is not prescribed. • Not billable for nursing home residents. • Level 13 = maximum PC dispensing fee. Notes: Titration or other dose adjustment must first be ruled out.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
NN (80) — The pharmacist determined continued therapy using a prescribed drug may not be necessary.	M0 (22) — Prescriber contacted.	2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$40.16 15-$40.16 ——————— Allowed PC dispensing fee code combinations: NN-M0-2A	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Summary of issue and therapeutic basis for recommendation. • Summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • List of discontinued drugs, if any. • R.Ph. identity. Limits: • A maximum of two Reason NN (80) PC dispensing fees per recipient, per year. • Result code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Not billable for nursing home residents. • Level 14 = maximum PC dispensing fee.

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
NS (32) — Prescribed quantity may be insufficient to treat this recipient's medical condition adequately according to medical literature. — Titration ruled out.	M0 (22) — Prescriber contacted.	1D (13) — Order filled with different directions. 1F (15) — Order filled with different quantity. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: NS-M0-1D+ NS-M0-1F+ NS-M0-2A + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Minimum expected quantity. • Source of minimum recommendation. • Outcome including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason NS (32) PC dispensing fees per recipient, per drug, per year. • A Reason NS (32) PC dispensing fee may not be claimed if titration is determined to be the basis for the "insufficient" quantity. • Level 13 = maximum PC dispensing fee.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
PS (17) — Product selection opportunity.	TH (12) — Therapeutic interchange.* * Action requires prescriber authorization.	1E (14) — Filled with different drug.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$40.11 15-$40.11 ——————— Allowed PC dispensing fee code combinations: PS-TH-1E+ + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify initial drug prescribed. • Summary of any communication with prescriber. • Changes made to drug(s), dose, frequency, directions, or quantity prescribed. • Indicate cost savings. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • Not to be used with drugs on the Medicaid MAC list. • Not to be used for generic substitution. • May only be used when therapeutic interchange results in drug cost savings. • Level 14 = maximum PC dispensing fee. Notes: The prescriber must be contacted for interchanges.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Level, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
RE (84) — In-home medication management.	AS (20) — Evaluation of information known by the pharmacist or supplied by the recipient for the purpose of developing a problem-based therapeutic plan. CC (21) — Coordination of care. M0 (22) — Prescriber contacted. MR (23) — Comprehensive review and evaluation of the recipient's complete known medication regimen. PE (25) — Verbal or written communication to the recipient by a pharmacist to enhance the recipient's knowledge about the condition under treatment or to develop skills and competencies related to its management.	3M (80) — Compliance aid developed. 3K (85) — Recipient demonstrates understanding of proper medication use.	Level-Fee 14-$40.11 Allowed PC dispensing fee code combinations: RE-AS-3M RE-CC-3K RE-M0-3K RE-MR-3K RE-PE-3M RE-PE-3K	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identification of drug(s) (when dispensed at same time as intervention). • Describe the medication management. • Describe the actions taken to solve the medication management problem and how it meets the recipient's needs. • Documentation of contact with physician ordering intervention. • Summarize the training provided to recipient in use of the medication. Include basis for recommendation. • R. Ph. identification. • Copy of physician order. • Describe the compliance aid developed and how it meets the recipient's needs. Limits: • A maximum of one Reason code RE (84) PC dispensing fee per recipient, per day. • Not available for nursing home residents or recipients receiving home health nurse services on the same days services are billed by home health. • Service must be delivered by a pharmacist or other licensed health care professional. • Physician order is required. Notes: Reason Code 84 must always be billed at Level 14.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
SC (83) — The recipient needs medication management assistance due to documented compliance problems.	AS (20) — Evaluation of information known by the pharmacist or supplied by the recipient for the purpose of developing a problem-based therapeutic plan.	3M (80) — The pharmacist designed, implemented, and provided recipient-specific training for a specific compliance aid program such as a "pill minder" or "punch card" system for in-home use.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$40.11 15-$40.11 Allowed PC dispensing fee code combinations: SC-AS-3M+ + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Describe the compliance problem, including the actual or potential negative recipient outcome of continued non-compliance. • Describe the compliance aid and how it meets the recipient's needs. • Summarize training provided to recipient in use of the compliance aid. • R.Ph. identity. Limits: • Not available for nursing home residents. • Maximum of two Reason SC (83) PC dispensing fees per recipient, per year. • Level 14 = maximum dispensing fee.

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
SE (95) — The pharmacist determines it necessary to provide information regarding possible side effects of a drug prescribed for this recipient. Side effect precautions include: Iatrogenic drug condition, drug-disease precaution, lactation precaution, drug-age precaution, drug-sex precaution, drug-food, drug-lab, drug-tobacco, drug-alcohol precautions.	M0 (22) — Prescriber contacted. PE (25) — Patient Education.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with a different drug. 1K (18) — Order filled with a different dosage form. 2A (30) — Order not filled. 3K (85) — Instructions understood.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: SE-M0-1C+ SE-M0-1D+ SE-M0-1E+ SE-M0-1K+ SE-M0-2A SE-PE-3K+ + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Summary of intervention. • Summary of side effect precaution for this drug and recipient. • Identify drug not filled. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of four Reason SE (95) PC dispensing fees per recipient per year. • Result code 2A (30) may only be indicated when *no* replacement drug is prescribed. • Not billable for nursing home residents. • Level 13 is the maximum PC dispensing fee if the prescriber is contacted. • Level 12 is the maximum PC dispensing fee for patient education when the prescriber is not contacted. Notes: Routine intervention is part of normal Prospective Drug Utilization Review (DUR) and consultation and is reimbursed under the "Traditional or Unit Dose" dispensing fee payment when the prescription is dispensed.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
SF (34) — Prescribed dosage form may be incorrect, inappropriate, or less than optimal for treating this recipient.	M0 (22) — Prescriber contacted.	1E (14) — Order filled with different drug. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: SF-M0-1E+ SF-M0-1K+ SF-M0-2A + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Nature of problem with dosage form. • Identify drug. • Summary of and basis for recommendation(s). • Outcome including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason SF (34) PC dispensing fees per recipient per drug per year. • A Reason SF (34) PC dispensing fee may not be claimed if titration is determined to be the basis for the less than optimal therapy. • Level 13 = maximum PC dispensing fee.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
SR (36) — Prescribed drug regimen may be incorrect or less than optimal for treating this recipient.	M0 (22) — Prescriber contacted.	IC (12) — Order filled with a different dose. 1D (13) — Order filled with different directions. 1F (15) — Order filled with different quantity. 1K (18) — Order filled with a different dosage form. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: SR-M0-1C+ SR-M0-1D+ SR-M0-1F+ SR-M0-1K+ SR-M0-2A + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify questioned drug(s). • Nature of problem with regimen. • Summary of and basis for recommendation(s). • Outcome including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of four Reason SR (36) PC dispensing fees per recipient, per year. • Result code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Level 13 = maximum PC dispensing fee.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
TD (59) — Recipient's drug regimen includes simultaneous use of one or more drugs with the same therapeutic effect or which contain identical generic chemical entities which may be inappropriate.	M0 (22) — Prescriber contacted.	1E (14) — Order filled with different drug. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: TD-M0-1E+ TD-M0-2A + Requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drugs. • Nature of multiple drug problem. • Summary of and basis for recommendation(s). • Outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason TD (59) PC dispensing fees per recipient, per drug combination, per year. • Result Code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Level 13 = maximum PC dispensing fee.

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
TN (85) — Based on medication profile review or recipient consultation, the pharmacist determined one or more laboratory tests should likely be performed.	RT (30) — The pharmacist recommends to the physician the performance of a clinical laboratory test for the recipient.	1C (12) — Filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Filled, different drug. 1K (18) — Filled, dose form change. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$14.68 14-$14.68 15-$14.68 ——————— Allowed PC dispensing fee code combinations: TN-RT-2A+ TN-RT-1D+ TN-RT-1E+ TN-RT-1K+ TN-RT-2A + requires linked drug NDC, same date of service.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Lab test recommended. • Summary of communication with the prescriber. • R.Ph. identity. Limits: • A maximum of one Reason TN (85) PC dispensing fee per recipient, per year. • Not billable for nursing home residents. • Level 12 is maximum PC dispensing fee.

Appendix 8

Wisconsin Medicaid Maximum Allowed Cost List For Pharmaceutical Care Codes

Reason	Action	Result	Level 11 1-5 min.	Level 12 6-15 min.	Level 13 16-30 min.	Level 14 31-60 min.	Level 15 61+ min.	R&S Message	Drug Detail	PC Fee Limits
AD	M0	1E	$9.45	$14.68	$22.16	$22.16	$22.16	ADD DRUG, MD, FILL/DIF DRUG	Y	2/pt/yr
AN	M0	2A	$9.45	$14.68	$22.16	$40.11	$40.11	FORGERY, MD, NOT FILLED	N	2/pt/yr
AN	R0	2A	$9.45	$14.68	$22.16	$40.11	$40.11	FORGERY, OTHERS, NOT FILLED	N	2/pt/yr
AN	TC	2A	$9.45	$14.68	$22.16	$40.11	$40.11	FORGERY, PAYOR, NOT FILLED	N	2/pt/yr
AR	M0	1C	$9.45	$14.68	$22.16	$22.16	$22.16	ADVER RXN, MD, DIF DOSE	Y	2/pt/yr
AR	M0	1D	$9.45	$14.68	$22.16	$22.16	$22.16	ADVER RXN, MD, DIF DIR	Y	2/pt/yr
AR	M0	1E	$9.45	$14.68	$22.16	$22.16	$22.16	ADVER RXN, MD, DIF DRUG	Y	2/pt/yr
AR	M0	1K	$9.45	$14.68	$22.16	$22.16	$22.16	ADVER RXN, MD, DIF FORM	Y	2/pt/yr
AR	M0	2A	$9.45	$14.68	$22.16	$22.16	$22.16	ADVER RXN, MD, NOT FILLED	N	2/pt/yr
AT	M0	1C	$9.45	$14.68	$22.16	$22.16	$22.16	ADD TOX, MD, DIF DOSE	Y	2/pt/yr
AT	M0	1D	$9.45	$14.68	$22.16	$22.16	$22.16	ADD TOX, MD, FILL/DIF DIR	Y	2/pt/yr
AT	M0	1E	$9.45	$14.68	$22.16	$22.16	$22.16	ADD TOX, MD, FILL/DIF DRUG	Y	2/pt/yr
AT	M0	1F	$9.45	$14.68	$22.16	$22.16	$22.16	ADD TOX, MD, FILLED/DIF QTY	Y	2/pt/yr
AT	M0	1K	$9.45	$14.68	$22.16	$22.16	$22.16	ADD TOX, MD, FILLED/DIF FORM	Y	2/pt/yr
AT	M0	2A	$9.45	$14.68	$22.16	$22.16	$22.16	ADD TOX, MD, NOT FILLED	N	2/pt/yr
AT	RT	1C	$9.45	$14.68	$22.16	$22.16	$22.16	ADD TOX, LAB, DIF DOSE	Y	2/pt/yr
AT	RT	1D	$9.45	$14.68	$22.16	$22.16	$22.16	ADD TOX, LAB, FILL/DIF DIR	Y	2/pt/yr
AT	RT	1E	$9.45	$14.68	$22.16	$22.16	$22.16	ADD TOX, LAB, FILL/DIF DRUG	Y	2/pt/yr
AT	RT	1F	$9.45	$14.68	$22.16	$22.16	$22.16	ADD TOX, LAB, FILLED/DIF QTY	Y	2/pt/yr
AT	RT	1K	$9.45	$14.68	$22.16	$22.16	$22.16	ADD TOX, LAB, FILLED/DIF FORM	Y	2/pt/yr
AT	RT	2A	$9.45	$14.68	$22.16	$22.16	$22.16	ADD TOX, LAB, NOT FILLED	N	2/pt/yr
CD	M0	1C	$9.45	$14.68	$22.16	$40.11	$40.11	DX-ASTHMA, MD, DIF DOSE	Y	6/pt/yr
CD	M0	1D	$9.45	$14.68	$22.16	$40.11	$40.11	DX-ASTHMA, MD, DIF DIR	Y	6/pt/yr
CD	M0	1E	$9.45	$14.68	$22.16	$40.11	$40.11	DX-ASTHMA, MD, DIF DRUG	Y	6/pt/yr
CD	M0	1K	$9.45	$14.68	$22.16	$40.11	$40.11	DX-ASTHMA, MD, DIF FORM	Y	6/pt/yr
CD	M0	2A	$9.45	$14.68	$22.16	$40.11	$40.11	DX-ASTHMA, MD, NOT FILLED	N	6/pt/yr

R&S = Remittance and Status.
PC Fee = Pharmaceutical Care Fee.

Appendix 8 continued

Reason	Action	Result	Level 11 1-5 min.	Level 12 6-15 min.	Level 13 16-30 min.	Level 14 31-60 min.	Level 15 61+ min.	R&S Message	Drug Detail	PC Fee Limits
CD	PE	3M	$9.45	$14.68	$22.16	$40.11	$40.11	DX-ASTHMA, PT, COMPLY AID	Y	6/pt/yr
CD	PE	3K	$9.45	$14.68	$22.16	$40.11	$40.11	DX-ASTHMA, PT, UNDRSTNDS	Y	6/pt/yr
CS	AS	3K	$9.45	$14.68	$22.16	$22.16	$22.16	PT SYMPTOM, AS, PT UNDRSTNDS	Y	1/pt/yr
CS	M0	1C	$9.45	$14.68	$22.16	$22.16	$22.16	PT SYMPTOM, MD, DIFF DOSE	Y	1/pt/yr
CS	M0	1D	$9.45	$14.68	$22.16	$22.16	$22.16	PT SYMPTOM, MD, DIFF DIR	Y	1/pt/yr
CS	M0	1E	$9.45	$14.68	$22.16	$22.16	$22.16	PT SYMPTOM, MD, DIFF DRUG	Y	1/pt/yr
CS	M0	1K	$9.45	$14.68	$22.16	$22.16	$22.16	PT SYMPTOM, MD, DIFF FORM	Y	1/pt/yr
CS	M0	2A	$9.45	$14.68	$22.16	$22.16	$22.16	PT SYMPTOM, MD, NOT FILLED	N	1/pt/yr
DA	M0	1E	$9.45	$14.68	$22.16	$22.16	$22.16	ALLERGY, MD, DIFF DRUG	Y	2/pt/yr
DA	M0	2A	$9.45	$14.68	$22.16	$22.16	$22.16	ALLERGY, MD, NOT FILLED	N	2/pt/yr
DD	M0	1C	$9.45	$14.68	$22.16	$22.16	$22.16	DRUG-DRUG, MD, FILL/DIF DOSE	Y	2/pt/yr
DD	M0	1E	$9.45	$14.68	$22.16	$22.16	$22.16	DRUG-DRUG, MD, FILL/DIF DRUG	Y	2/pt/yr
DD	M0	2A	$9.45	$14.68	$22.16	$22.16	$22.16	DRUG-DRUG, MD, NOT FILLED	N	2/pt/yr
DI	M0	1E	$9.45	$14.68	$22.16	$22.16	$22.16	IV INCOMP, MD, DIF DRUG	Y	2/pt/yr
DI	M0	2A	$9.45	$14.68	$22.16	$22.16	$22.16	IV INCOMP, MD, NOT FILLED	N	2/pt/yr
DM	M0	1C	$9.45	$14.68	$22.16	$40.11	$40.11	MISUSE, MD, FILLED/DIF DOSE	Y	2/pt/yr
DM	M0	1D	$9.45	$14.68	$22.16	$40.11	$40.11	MISUSE, MD, FILLED/DIF DIR	Y	2/pt/yr
DM	M0	1E	$9.45	$14.68	$22.16	$40.11	$40.11	MISUSE, MD, FILLED/DIF DRUG	Y	2/pt/yr
DM	M0	1F	$9.45	$14.68	$22.16	$40.11	$40.11	MISUSE, MD, FILLED/DIF QTY	Y	2/pt/yr
DM	M0	1K	$9.45	$14.68	$22.16	$40.11	$40.11	MISUSE, MD, FILLED/DIF FORM	Y	2/pt/yr
DM	M0	2A	$9.45	$14.68	$22.16	$40.11	$40.11	MISUSE, MD, NOT FILLED	N	2/pt/yr
DM	M0	3M	$9.45	$14.68	$22.16	$40.11	$40.11	MISUSE, MD, PT, COMPLY AID	Y	2/pt/yr
DM	M0	3K	$9.45	$14.68	$22.16	$40.11	$40.11	MISUSE, MD, PT UNDRSTNDS	Y	2/pt/yr
ER	M0	1C	$9.45	$14.68	$22.16	$22.16	$22.16	E REF, MD, CHG DOSE	Y	4/pt/yr
ER	M0	1D	$9.45	$14.68	$22.16	$22.16	$22.16	E REF, MD, FIL/DIF DIR	Y	4/pt/yr
ER	M0	1F	$9.45	$14.68	$22.16	$22.16	$22.16	E REF, MD, FIL/DIF QTY	Y	4/pt/yr
ER	M0	1K	$9.45	$14.68	$22.16	$22.16	$22.16	E REF, MD, DOSE FORM CHG	Y	4/pt/yr
ER	M0	2A	$9.45	$14.68	$22.16	$22.16	$22.16	E REF, MD, NOT FILLED	N	4/pt/yr

R&S = Remittance and Status.
PC Fee = Pharmaceutical Care Fee.

Appendix 8
continued

Reason	Action	Result	Level 11 1-5 min.	Level 12 6-15 min.	Level 13 16-30 min.	Level 14 31-60 min.	Level 15 61+ min.	R&S Message	Drug Detail	PC Fee Limits
ER	PE	3M	$9.45	$14.68	$14.68	$14.68	$14.68	E REF, PT ED, PT COMP AID	Y	4/pt/yr
ER	PE	3K	$9.45	$14.68	$14.68	$14.68	$14.68	E REF, PT ED, UNDRSTNDS	Y	4/pt/yr
ER	PE	2A	$9.45	$14.68	$14.68	$14.68	$14.68	E REF, PT ED, NOT FILLED	N	4/pt/yr
EX	M0	1C	$9.45	$14.68	$22.16	$22.16	$22.16	EX QTY, MD, FILL/DIF DOSE	Y	2/pt/yr
EX	M0	1D	$9.45	$14.68	$22.16	$22.16	$22.16	EX QTY, MD, FILL/DIF DIR	Y	2/pt/yr
EX	M0	1E	$9.45	$14.68	$22.16	$22.16	$22.16	EX QTY, MD, FILL/DIF DRUG	Y	2/pt/yr
EX	M0	1F	$9.45	$14.68	$22.16	$22.16	$22.16	EX QTY, MD, FILL/DIF QTY	Y	2/pt/yr
EX	M0	1K	$9.45	$14.68	$22.16	$22.16	$22.16	EX QTY, MD, FILL/DIF FORM	Y	2/pt/yr
EX	M0	2A	$9.45	$14.68	$22.16	$22.16	$22.16	EX QTY, MD, NOT FILLED	N	2/pt/yr
HD	M0	1C	$9.45	$14.68	$22.16	$22.16	$22.16	H DOSE, MD, FILL/DIF DOSE	Y	2/pt/yr
HD	M0	1D	$9.45	$14.68	$22.16	$22.16	$22.16	H DOSE, MD, FILL/DIF DIR	Y	2/pt/yr
HD	M0	1E	$9.45	$14.68	$22.16	$22.16	$22.16	H DOSE, MD, FILL/DIF DRUG	Y	2/pt/yr
HD	M0	1K	$9.45	$14.68	$22.16	$22.16	$22.16	H DOSE, MD, FILL/DIF FORM	Y	2/pt/yr
HD	M0	2A	$9.45	$14.68	$22.16	$22.16	$22.16	H DOSE, MD, NOT FILLED	N	2/pt/yr
LD	M0	1C	$9.45	$14.68	$22.16	$22.16	$22.16	L DOSE, MD, FILL/DIF DOSE	Y	2/pt/yr
LD	M0	1D	$9.45	$14.68	$22.16	$22.16	$22.16	L DOSE, MD, FILL/DIF DIR	Y	2/pt/yr
LD	M0	1E	$9.45	$14.68	$22.16	$22.16	$22.16	L DOSE, MD, FILL/DIF DRUG	Y	2/pt/yr
LD	M0	1F	$9.45	$14.68	$22.16	$22.16	$22.16	L DOSE, MD, FILL/DIF QTY	Y	2/pt/yr
LD	M0	1K	$9.45	$14.68	$22.16	$22.16	$22.16	L DOSE, MD, FILL/DIF FORM	Y	2/pt/yr
LD	M0	2A	$9.45	$14.68	$22.16	$22.16	$22.16	L DOSE, MD, NOT FILLED	N	2/pt/yr
LK	CC	1C	$9.45	$14.68	$22.16	$40.11	$40.11	LOCKIN, CORCARE, DIF DOSE	Y	15/pt/yr
LK	CC	1D	$9.45	$14.68	$22.16	$40.11	$40.11	LOCKIN, CORCARE, DIF DIR	Y	15/pt/yr
LK	CC	1E	$9.45	$14.68	$22.16	$40.11	$40.11	LOCKIN, CORCARE, DIF DRUG	Y	15/pt/yr
LK	CC	1F	$9.45	$14.68	$22.16	$40.11	$40.11	LOCKIN, CORCARE, DIF QTY	Y	15/pt/yr
LK	CC	1K	$9.45	$14.68	$22.16	$40.11	$40.11	LOCKIN, CORCARE, DIF FORM	Y	15/pt/yr
LK	CC	2A	$9.45	$14.68	$22.16	$40.11	$40.11	LOCKIN, CORCARE, NOT FILLED	N	15/pt/yr

R&S = Remittance and Status.
PC Fee = Pharmaceutical Care Fee.

Appendix 8 continued

Reason	Action	Result	Level 11 1-5 min.	Level 12 6-15 min.	Level 13 16-30 min.	Level 14 31-60 min.	Level 15 61+ min.	R&S Message	Drug Detail	PC Fee Limits
LK	CC	3K	$9.45	$14.68	$22.16	$40.11	$40.11	LOCKIN, CORCARE, UNDRSTND	Y	15/pt/yr
LK	M0	1C	$9.45	$14.68	$22.16	$40.11	$40.11	LOCKIN, MD, DIF DOSE	Y	15/pt/yr
LK	M0	1D	$9.45	$14.68	$22.16	$40.11	$40.11	LOCKIN, MD, DIF DIR	Y	15/pt/yr
LK	M0	1E	$9.45	$14.68	$22.16	$40.11	$40.11	LOCKIN, MD, DIF DRUG	Y	15/pt/yr
LK	M0	1F	$9.45	$14.68	$22.16	$40.11	$40.11	LOCKIN, MD, DIF QTY	Y	15/pt/yr
LK	M0	1K	$9.45	$14.68	$22.16	$40.11	$40.11	LOCKIN, MD, DIF FORM	Y	15/pt/yr
LK	M0	2A	$9.45	$14.68	$22.16	$40.11	$40.11	LOCKIN, MD, NOT FILLED	N	15/pt/yr
LK	M0	3K	$9.45	$14.68	$22.16	$40.11	$40.11	LOCKIN, MD, UNDRSTND	Y	15/pt/yr
LK	PE	2A	$9.45	$14.68	$22.16	$40.11	$40.11	LOCKIN, PT ED, NOT FILLED	N	15/pt/yr
LK	PE	3K	$9.45	$14.68	$22.16	$40.11	$40.11	LOCKIN, PT ED, UNDRSTND	Y	15/pt/yr
LK	TC	2A	$9.45	$14.68	$22.16	$40.11	$40.11	LOCKIN, PAYOR, NOT FILLED	N	15/pt/yr
LK	TC	3K	$9.45	$14.68	$22.16	$40.11	$40.11	LOCKIN, PAYOR, UNDRSTND	N	15/pt/yr
LR	M0	1C	$9.45	$14.68	$22.16	$22.16	$22.16	L REF, MD, DIF DOSE	Y	4/pt/yr
LR	M0	1D	$9.45	$14.68	$22.16	$22.16	$22.16	L REF, MD, FILL/DIF DIR	Y	4/pt/yr
LR	M0	1E	$9.45	$14.68	$22.16	$22.16	$22.16	L REF, MD, FILL/DIF DRUG	Y	4/pt/yr
LR	M0	1F	$9.45	$14.68	$22.16	$22.16	$22.16	L REF, MD, FILL/DIF QTY	Y	4/pt/yr
LR	M0	1K	$9.45	$14.68	$22.16	$22.16	$22.16	L REF, MD, CHG DOSE FORM	Y	4/pt/yr
LR	M0	2A	$9.45	$14.68	$22.16	$22.16	$22.16	L REF, MD, NOT FILLED	N	4/pt/yr
LR	PE	3M	$9.45	$14.68	$14.68	$14.68	$14.68	L REF, PT ED, COMPLY AID	Y	4/pt/yr
LR	PE	3K	$9.45	$14.68	$14.68	$14.68	$14.68	L REF, PT ED, UNDRSTNDS	Y	4/pt/yr
MN	M0	1D	$9.45	$14.68	$22.16	$22.16	$22.16	INSF DUR, MD, FILL/DIF DIR	Y	2/pt/yr
MN	M0	1F	$9.45	$14.68	$22.16	$22.16	$22.16	INSF DUR, MD, FILL/DIF QTY	Y	2/pt/yr
MN	M0	2A	$9.45	$14.68	$22.16	$22.16	$22.16	INSF DUR, MD, NOT FILLED	N	2/pt/yr
MX	M0	1C	$9.45	$14.68	$22.16	$22.16	$22.16	EX DUR, MD, FILL/DIF DOSE	Y	2/pt/yr
MX	M0	1D	$9.45	$14.68	$22.16	$22.16	$22.16	EX DUR, MD, FILL/DIF DIR	Y	2/pt/yr
MX	M0	1E	$9.45	$14.68	$22.16	$22.16	$22.16	EX DUR, MD, FILL/DIF DRUG	Y	2/pt/yr

R&S = Remittance and Status.
PC Fee = Pharmaceutical Care Fee.

Appendix 8
continued

Reason	Action	Result	Level 11 1-5 min.	Level 12 6-15 min.	Level 13 16-30 min.	Level 14 31-60 min.	Level 15 61+ min.	R&S Message	Drug Detail	PC Fee Limits
MX	M0	1F	$9.45	$14.68	$22.16	$22.16	$22.16	EX DUR, MD, FILL/DIF QTY	Y	2/pt/yr
MX	M0	1K	$9.45	$14.68	$22.16	$22.16	$22.16	EX DUR, MD, FILL/DIF FORM	Y	2/pt/yr
MX	M0	2A	$9.45	$14.68	$22.16	$22.16	$22.16	EX DUR, MD, NOT FILLED	N	2/pt/yr
NN	M0	2A	$9.45	$14.68	$22.16	$40.16	$40.16	UNNEC DRG, MD, NOT FILLED	N	2/pt/yr
NS	M0	1D	$9.45	$14.68	$22.16	$22.16	$22.16	INSF QTY, MD, FILL/DIF DIR	Y	2/pt/yr
NS	M0	1F	$9.45	$14.68	$22.16	$22.16	$22.16	INSF QTY, MD, FILL/DIF QTY	N	2/pt/yr
NS	M0	2A	$9.45	$14.68	$22.16	$22.16	$22.16	INSF QTY, MD, NOT FILLED	N	2/pt/yr
PS	TH	1E	$9.45	$14.68	$22.16	$40.11	$40.11	PRODSLCT, INTRCHG, DIF DRUG	Y	None
RE	AS	3M	n/a	n/a	n/a	$40.11	n/a	INHOME, ASSESS, COMPLY AID	Y	1/pt/dy
RE	CC	3K	n/a	n/a	n/a	$40.11	n/a	INHOME, CORCARE, PT UNDRSTD	Y	1/pt/dy
RE	M0	3K	n/a	n/a	n/a	$40.11	n/a	INHOME, MD, PT UNDRSTNDS	Y	1/pt/dy
RE	MR	3K	n/a	n/a	n/a	$40.11	n/a	INHOME, MEDREV, PT UNDRSTD	Y	1/pt/dy
RE	PE	3M	n/a	n/a	n/a	$40.11	n/a	INHOME, PT ED, PT COMPLY AID	Y	1/pt/dy
RE	PE	3K	n/a	n/a	n/a	$40.11	n/a	INHOME, PT ED, PT UNDRSTND	Y	1/pt/dy
SC	AS	3M	$9.45	$14.68	$22.16	$40.11	$40.11	COMPLY, ASSESS, COMPLY AID	Y	2/pt/yr
SE	M0	1C	$9.45	$14.68	$22.16	$22.16	$22.16	SIDE-EF, MD, FILL/DIFF DOSE	Y	4/pt/yr
SE	M0	1D	$9.45	$14.68	$22.16	$22.16	$22.16	SIDE-EF, MD, FILL/DIFF DIR	Y	4/pt/yr
SE	M0	1E	$9.45	$14.68	$22.16	$22.16	$22.16	SIDE-EF, MD, FILL/DIFF DRUG	Y	4/pt/yr
SE	M0	1K	$9.45	$14.68	$22.16	$22.16	$22.16	SIDE-EF, MD, FILL/DIFF FORM	Y	4/pt/yr
SE	M0	2A	$9.45	$14.68	$22.16	$22.16	$22.16	SIDE-EF, MD, NOT FILLED	N	4/pt/yr
SE	PE	3K	$9.45	$14.68	$14.68	$14.68	$14.68	SIDE-EF, PT ED, UNDRSTNDS	Y	4/pt/yr
SF	M0	1E	$9.45	$14.68	$22.16	$22.16	$22.16	DOSE FORM, MD, FILL/DIFF DRUG	Y	2/pt/yr

R&S = Remittance and Status.
PC Fee = Pharmaceutical Care Fee.

Appendix 8 continued

Reason	Action	Result	Level 11 1-5 min.	Level 12 6-15 min.	Level 13 16-30 min.	Level 14 31-60 min.	Level 15 61+ min.	R&S Message	Drug Detail	PC Fee Limits
SF	M0	1K	$9.45	$14.68	$22.16	$22.16	$22.16	DOSE FORM, MD, FILL/DIFF FORM	Y	2/pt/yr
SF	M0	2A	$9.45	$14.68	$22.16	$22.16	$22.16	DOSE FORM, MD, NOT FILLED	N	2/pt/yr
SR	M0	1C	$9.45	$14.68	$22.16	$22.16	$22.16	REGM PROB, MD, FILL/DIF DOSE	Y	4/pt/yr
SR	M0	1D	$9.45	$14.68	$22.16	$22.16	$22.16	REGM PROB, MD, FILL/DIF DIR	Y	4/pt/yr
SR	M0	1F	$9.45	$14.68	$22.16	$22.16	$22.16	REGM PROB, MD, FILL/DIF QTY	Y	4/pt/yr
SR	M0	1K	$9.45	$14.68	$22.16	$22.16	$22.16	REGM PROB, MD, FILL/DIF FORM	Y	4/pt/yr
SR	M0	2A	$9.45	$14.68	$22.16	$22.16	$22.16	REGM PROB, MD, NOT FILLED	N	4/pt/yr
TD	M0	1E	$9.45	$14.68	$22.16	$22.16	$22.16	THER DUPE, MD, FILL/DIFF DRUG	Y	2/pt/yr
TD	M0	2A	$9.45	$14.68	$22.16	$22.16	$22.16	THER DUPE, MD, NOT FILLED	N	2/pt/yr
TN	RT	1C	$9.45	$14.68	$14.68	$14.68	$14.68	LAB TEST, RECOM, DIF DOSE	Y	1/pt/yr
TN	RT	1D	$9.45	$14.68	$14.68	$14.68	$14.68	LAB TEST, RECOM, DIF DIR	Y	1/pt/yr
TN	RT	1E	$9.45	$14.68	$14.68	$14.68	$14.68	LAB TEST, RECOM, DIF DRUG	Y	1/pt/yr
TN	RT	1K	$9.45	$14.68	$14.68	$14.68	$14.68	LAB TEST, RECOM, DIF FORM	Y	1/pt/yr
TN	RT	2A	$9.45	$14.68	$14.68	$14.68	$14.68	LAB TEST, RECOM, NOT FILLED	N	1/pt/yr

R&S = Remittance and Status.
PC Fee = Pharmaceutical Care Fee.

Appendix 9

Wisconsin Medicaid Pharmaceutical Care Level of Service Definitions

Level 10 *Traditional or Unit Dose (UD) Dispensing Fee*	*Basic Prescription Service — No Pharmaceutical Care (PC) Provided* Meets all dispensing requirements including record keeping, profiles prospective Drug Utilization Review (DUR), and counseling. No PC coding required.
Level 11 *PC Dispensing Fee* (1-5 minutes, excluding documentation time)	*Pharmaceutical Care, Level I* Compliant with all dispensing requirements including record keeping, prospective DUR, and counseling. In addition to the basic service requirements, a PC chart must be maintained plus additional PC provided, usually requiring less than six minutes of the pharmacist's time. Requires intended use/diagnosis for all drugs prescribed for this patient and *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each PC intervention submitted.
Level 12 *PC Dispensing Fee* (6-15 minutes, excluding documentation time)	*Pharmaceutical Care, Level II* Compliant with all basic dispensing requirements including record keeping, prospective DUR, and counseling. In addition to the basic service requirements, a PC chart must be maintained plus additional PC provided, requiring six to 16 minutes of the pharmacist's time. Requires intended use/diagnosis for all drugs prescribed for this patient and ICD-9-CM diagnosis code for each PC intervention submitted.
Level 13 *PC Dispensing Fee* (16-30 minutes, excluding documentation time)	*Pharmaceutical Care, Level III* Compliant with all basic dispensing requirements including record keeping, prospective DUR, and counseling. In addition to the basic service requirements, a PC chart must be maintained plus additional PC provided requiring 16 to 30 minutes of the pharmacist's time. Requires intended use/diagnosis for all drugs prescribed for this patient and ICD-9-CM diagnosis code for each PC intervention submitted.
Level 14 *PC Dispensing Fee* (31-60 minutes, excluding documentation time)	*Pharmaceutical Care, Level IV* Compliant with all basic dispensing requirements including record keeping, prospective DUR, and counseling. In addition to the basic service requirements, a PC chart must be maintained plus additional PC provided requiring 31 to 60 minutes of the pharmacist's time. Requires intended use/diagnosis for all drugs prescribed for this patient and ICD-9-CM diagnosis code for each PC intervention submitted.
Level 15 *PC Dispensing Fee* (Over 60 minutes, excluding documentation time)	*Pharmaceutical Care, Level V* Compliant with all basic dispensing requirements including record keeping, prospective DUR, and counseling. In addition to the basic service requirements, a PC chart must be maintained plus additional PC provided requiring more than 60 minutes of the pharmacist's time. Requires intended use/diagnosis for all drugs prescribed for this patient and ICD-9-CM diagnosis code for each PC intervention submitted. This PC pays at level 14.

Appendix 10

Sample Paper Claim Form — Pharmaceutical Care

Form 98-1141 (8/98). Replaces 482-020
Authorized under HFS 106.03 (1), Wis. Admin. Code

Return to:

EDS
6406 Bridge Road
Madison, WI 53784-0002

ICN (DO NOT WRITE IN THIS SPACE)

1. PROVIDER NAME AND ADDRESS
I.M. Provider
1 West Williams
Anytown, WI 55555

2. PROVIDER NUMBER
12345678

Wisconsin Medicaid

NON-COMPOUND DRUG CLAIM FORM

RECIPIENT INFORMATION

3. MEDICAID NUMBER	4. LAST NAME	5. FIRST NAME	6. SEX	7. DATE OF BIRTH
1234567890	Recipient	Ima	2	08/28/72

CLAIM INFORMATION

1

8. PRESCRIBER NUMBER	9. DATE PRESCRIBED	10. DATE FILLED	11. REFILL	12. NDC	13. DAYS SUPPLY	14. QUANTITY	15. CHARGE
AS7654321	12/20/00	12/20/00	00 00	00168 0199 15	30	15	$ XX.XX

16. UD	17. PRESCRIPTION NUMBER	18. MAC	19. DRUG DESCRIPTION	20. POS
0	3942877	0	Timolol 0.25% eye drops	08

21. DIAGNOSIS CODE	22. LEVEL OF SERVICE	23. DUR CONF./REASON	24. DUR INTERVENTION	25. DUR OUTCOME
V72.0	13	EX	MO	1C

2

8. PRESCRIBER NUMBER	9. DATE PRESCRIBED	10. DATE FILLED	11. REFILL	12. NDC	13. DAYS SUPPLY	14. QUANTITY	15. CHARGE
AS1234567	11/20/00	12/20/00	00 00	00781 1232 13	30	60	$ XX.XX

16. UD	17. PRESCRIPTION NUMBER	18. MAC	19. DRUG DESCRIPTION	20. POS
1	1279433	0	Enalapril 10 mg tablet	08

21. DIAGNOSIS CODE	22. LEVEL OF SERVICE	23. DUR CONF./REASON	24. DUR INTERVENTION	25. DUR OUTCOME

3

8. PRESCRIBER NUMBER	9. DATE PRESCRIBED	10. DATE FILLED	11. REFILL	12. NDC	13. DAYS SUPPLY	14. QUANTITY	15. CHARGE
							$

16. UD	17. PRESCRIPTION NUMBER	18. MAC	19. DRUG DESCRIPTION	20. POS

21. DIAGNOSIS CODE	22. LEVEL OF SERVICE	23. DUR CONF./REASON	24. DUR INTERVENTION	25. DUR OUTCOME

4

8. PRESCRIBER NUMBER	9. DATE PRESCRIBED	10. DATE FILLED	11. REFILL	12. NDC	13. DAYS SUPPLY	14. QUANTITY	15. CHARGE
							$

16. UD	17. PRESCRIPTION NUMBER	18. MAC	19. DRUG DESCRIPTION	20. POS

21. DIAGNOSIS CODE	22. LEVEL OF SERVICE	23. DUR CONF./REASON	24. DUR INTERVENTION	25. DUR OUTCOME

26. CERTIFICATION

I certify the services and items for which reimbursement is claimed on this claim form were provided to the above named recipient pursuant to the prescription of a licensed physician, podiatrist, or dentist. Charges on this claim form do not exceed my (our) usual and customary charge for the same services or items when provided to persons not entitled to receive benefits under Wisconsin Medicaid.
I understand that any payment made in satisfaction of this claim will be derived from federal and state funds and that any false claims, statements or documents, or concealment of a material fact may be subject to prosecution under applicable federal or state law.

PHARMACIST'S OR DISPENSING PHYSICIAN'S SIGNATURE I.M. Provider DATE 01/01/01

27. PRIOR AUTHORIZATION NUMBER

28. O.C.

PLACE OF SERVICE (POS)	DESCRIPTION
00	PHARMACY
01	HOME (IV-IM SERVICES ONLY)
07	SKILLED CARE FACILITY
08	SUB-ACUTE CARE FACILITY
10	OUTPATIENT (DOCTOR'S OFFICE)

30. O.C. AMOUNT $XX.XX

31. PATIENT PAID $

32. NET BILLED $XX.XX

Glossary of Common Terms

Adjustment

A modified or changed claim that was originally allowed, at least in part, by Wisconsin Medicaid.

Alerts

Screen pharmacy claims for clinically important potential drug therapy problems before the prescription is dispensed to the recipient. The following alerts will be returned to the provider:

- DD — Drug to Drug.
- MC — Reported Disease.
- DC — Inferred Disease.
- TD — Therapeutic Duplication.
- PG — Pregnancy.
- ER — Early Refill.
- AT — Additive Toxicity.
- PA — Patient Age.
- LR — Late Refill.

Allowed status

A Medicaid or Medicare claim that has at least one service that is reimbursable.

BadgerCare

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid, and recipients' health care is administered through the same delivery system.

CPT

Current Procedural Terminology. A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by the Health Care Financing Administration (HCFA) and Wisconsin Medicaid.

Crossover claim

A Medicare-allowed claim for a dual entitlee sent to Wisconsin Medicaid for possible additional payment of the Medicare coinsurance and deductible.

DHCF

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid program that provides the Health Care Financing Administration (HCFA) and the U.S. Department of Health and Human Services (DHHS), assurances that the program is administered in conformity with federal law and HCFA policy.

DHFS

Wisconsin Department of Health and Family Services. The DHFS administers the Wisconsin Medicaid program. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DHHS

Department of Health and Human Services. The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

DOS

Date of service. The calendar date on which a specific medical service is performed.

Dual entitlee

A recipient who is eligible for both Medicaid and Medicare, either Medicare Part A, Part B, or both.

DUR

Drug Utilization Review. There are two components of DUR, prospective and retrospective. Prospective DUR is a system within the Pharmacy POS system that assists pharmacy providers in screening selected drug categories for clinically important potential drug therapy problems before the prescription is dispensed to the recipient. Retrospective DUR screens after the prescription has been dispensed to the recipient through drug profiling and peer grouping.

EMC

Electronic Media Claims. Method of claims submission through a personal computer or mainframe system. Claims can be mailed on tape or transmitted via telephone and modem.

Emergency services

Those services which are necessary to prevent death or serious impairment of the health of the individual. (For the Medicaid managed care definition of emergency, refer to the Managed Care Guide or the Medicaid managed care contract.)

EOB

Explanation of Benefits. Appears on the provider's Remittance and Status (R/S) Report and informs Medicaid providers of the status of or action taken on their claims.

EVS

Eligibility Verification System. Wisconsin Medicaid encourages all providers to verify eligibility before rendering services, both to determine eligibility for the current date and to discover any limitations to a recipient's coverage. Providers may access recipient eligibility information through the following methods:

- Automated Voice Response (AVR) system.
- Magnetic stripe card readers.
- Personal computer software.
- Provider Services (telephone correspondents).
- Direct Information Access Line with Updates for Providers (Dial-Up).

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

Fiscal agent

The Department of Health and Family Services (DHFS) contracts with Electronic Data Systems (EDS) to provide health claims processing services for Wisconsin Medicaid, including provider certification, claims payment, provider services, and recipient services. The fiscal agent also issues identification cards to recipients, publishes information for providers and recipients, and maintains the Wisconsin Medicaid Web site.

HCFA

Health Care Financing Administration. An agency housed within the U.S. Department of Health and Human Services (DHHS), HCFA administers Medicare, Medicaid, related quality assurance programs, and other programs.

HCPCS

HCFA Common Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes *Current Procedural Terminology* (CPT) codes, national alphanumeric codes, and local alphanumeric codes. The national codes are developed by the Health Care Financing Administration (HCFA) to supplement CPT codes.

HealthCheck

Program which provides Medicaid-eligible children under age 21 with regular health screenings.

ICD-9-CM

International Classification of Diseases, Ninth Revision, Clinical Modification. Nomenclature for medical diagnoses required for billing. Available through the American Hospital Association.

LOS

Level of service. Field required when billing Pharmaceutical Care services or compound drugs indicating the time associated with the service provided.

Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

Medically necessary

According to HFS 101.03(96m), Wis. Admin. Code, a Medicaid service that is:

a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
b) Meets the following standards:
    1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
    2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;
    3. Is appropriate with regard to generally accepted standards of medical practice;
    4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
    5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature.
    6. Is not duplicative with respect to other services being provided to the recipient.
    7. Is not solely for the convenience of the recipient, the recipient's family or a provider.
    8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient.
    9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

NCPDP

National Council for Prescription Drug Programs. This entity governs the telecommunication formats used to submit prescription claims electronically.

NDC

National Drug Code. An 11-digit code assigned to each drug. The first five numbers indicate the labeler code (Health Care Financing Administration [HCFA]-assigned), the next four numbers indicate the drug and strength (labeler assigned), and the remaining two numbers indicate the package size (labeler assigned).

OBRA

Omnibus Budget Reconciliation Act. Federal legislation that defines Medicaid drug coverage requirements and drug rebate rules.

OTC

Over-the-counter. Drugs that non-Medicaid recipients can obtain without a prescription.

PA

Prior authorization. The electronic or written authorization issued by the Department of Health and Family Services (DHFS) to a provider prior to the provision of a service.

PC

Pharmaceutical Care. An enhanced dispensing fee paid to providers for specified activities which result in a positive outcome. Some outcomes include increasing patient compliance or preventing potential adverse drug reactions.

POS

Point-of-Sale. A system that enables Medicaid providers to submit electronic pharmacy claims in an on-line, real-time environment.

Real-time response
Information returned to a provider for a real-time claim indicating claim payment or denial.

R/S Report
Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform providers regarding the processing of their claims.

STAT-PA
Specialized Transmission Approval Technology — Prior Authorization. An electronic PA system that allows Medicaid-certified pharmacy providers to request and receive PA electronically rather than by mail for certain drugs.

Switch transmissions
System that routes real-time transmissions from a pharmacy to the processor. Also called Clearinghouse or Value-Added Network (VAN) system.

TOS
Type of service. A single-digit code which identifies the general category of a procedure code.

UD
Unit Dose Dispensing Fee. Reimbursement to providers when a qualified unit dose dispensing system is used. The drugs may be packaged into unit doses by the labeler or the provider.

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